



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Houston Medical Group – South

Respondent Name

ACE American Insurance Company

MFDR Tracking Number

M4-16-1145-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

December 31, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Initially the claim was denied because the insurance stated the above mentioned reasons so I appealed it on 10/09/2015 with the corrected information. Again the appeal was denied for the exact same reason."

Amount in Dispute: \$630.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money."

Response Submitted by: ESIS Bill Review

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 3 – 25, 2015	Physical Therapy (97110, 97140)	\$630.66	\$107.39

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:

Date of service 2/3/15:

- 334 – Billed charges are equal to \$0.00. Allowance is not recommended.
- 417 – Resubmit bill with appropriate ICD-9 diagnosis codes: 845.0 is invalid

Date of service 2/13/15:

- 148 – This procedure on this date was previously reviewed
- 417 – Resubmit with appropriate ICD-9 diagnosis codes: <InvDXs>
- ANSI146 – Diagnosis was invalid for the date(s) of service reported.
- ANSI118 – Duplicate claim/service.

Date of service 2/25/15:

- 330 – CCI Comprehensive/Component procedure.
- 402 – The appropriate modifier was not utilized
- ANSI236 – This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the NCCI edits or work comp state regs/fee schedule requirements.

Issues

1. What are the services in question for this dispute?
2. Are the insurance carrier's reasons for denial of payment for date of service February 13, 2015 supported?
3. Are the insurance carrier's reasons for denial of payment for date of service February 25, 2015 supported?
4. What is the maximum allowable reimbursement (MAR) for the disputed services?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking \$0.00 for the following services included on the Medical Fee Dispute Resolution Request (DWC060):

Date of Service	Procedure Code
2/13/2015	99212-25
2/13/2015	98940
2/25/2015	98940
2/25/2015	97110-GP-59

Therefore, these services will not be considered in this dispute.

The insurance carrier did not maintain denial and made a partial reimbursement of the following services subsequent to the requestor's filing of the medical fee dispute:

Date of Service	Procedure Code	Requested	Paid
2/3/2015	97110-GP-59	\$214.08	\$130.29
2/3/2015	97140-GP	\$67.50	\$36.47
2/13/2015	97110-GP-59	\$214.08	\$51.72

Therefore, these services will be reviewed in accordance with the fee guidelines found in 28 Texas Administrative Code §134.203.

The following services remain denied in full:

Date of Service	Procedure Code
2/13/2015	97140-GP
2/25/2015	97140-GP

These services will be reviewed in accordance with applicable rules and guidelines.

2. The insurance carrier denied procedure code 97140 on date of service February 13, 2015 with claim adjustment reason codes 417 – “Resubmit with appropriate ICD-9 diagnosis codes: <InvDXs>,” and ANSI146 – “Diagnosis was invalid for the date(s) of service reported.”

Review of the submitted documentation finds that the requestor billed with diagnosis codes 845.09 and 847.2. Diagnosis code 845.09 is defined as "Other ankle sprain and strain," and diagnosis code 847.2 is defined as "Lumbar sprain and strain." The insurance carrier's denial for this reason is not supported.

In their position statement the insurance carrier states, "Date of service 2/13/15 – ... Code 97140-GP requires a modifier 59 when billed with 98940."

28 Texas Administrative Code §133.307(d)(2)(F) states, in relevant part,

The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

The division finds that this denial reason was not presented to the requestor prior to the date the request for MFDR was filed. Therefore, this issue will not be considered for this service. The disputed services will therefore be reviewed in accordance with the fee guidelines found in 28 Texas Administrative Code §134.203.

3. The insurance carrier denied procedure code 97140 on date of service February 25, 2015 with the following claim adjustment reason codes:
 - 330 – CCI Comprehensive/Component procedure.
 - 402 – The appropriate modifier was not utilized
 - ANSI236 – This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the NCCI edits or work comp state regs/fee schedule requirements.

28 Texas Administrative Code §134.203(b) requires that

For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

- (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

A review of the Medicare CCI edits finds that billed procedure code 98940 has a conflict with procedure code 97140, which may be overcome with a modifier. The submitted documentation does not support that procedure code 97140 was billed with a modifier that overcomes this edit. The insurance carrier's denial reason for this service is supported. Additional reimbursement cannot be recommended.

4. 28 Texas Administrative Code §134.203(c) states,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

- (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83...
- (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year...

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The Division conversion factor for 2015 is \$56.20.

For CPT code 97110 on February 3, 2015, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 0.450000. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.920 is 0.404800. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with

the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The reduced PE for subsequent units is 0.202400. The malpractice RVU of 0.02 multiplied by the malpractice (MP) GPCI of 0.822 is 0.016440. The sum of the calculations for the first unit, 0.871240, is multiplied by the Division conversion factor of \$56.20 for a total of \$48.96. The sum of the calculations for subsequent units, 0.668840, is multiplied by the Division conversion factor of \$56.20 for a total of \$37.59. The total MAR for 3 units is \$124.14.

For CPT code 97140 on February 3, 2015, the RVU for work of 0.43 multiplied by the GPCI for work of 1.000 is 0.430000. The PE RVU of 0.40 multiplied by the PE GPCI of 0.920 is 0.368000. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The reduced PE is 0.184000. The MP RVU of 0.01 multiplied by the malpractice GPCI of 0.822 is 0.008220. The sum of 0.622220 is multiplied by the Division conversion factor of \$56.20 for a total of \$34.97. The total MAR for 1 unit is \$34.97.

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For CPT code 97140 on February 13, 2015, the RVU for work of 0.43 multiplied by the GPCI for work of 1.000 is 0.430000. The PE RVU of 0.40 multiplied by the PE GPCI of 0.920 is 0.368000. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The reduced PE is 0.184000. The MP RVU of 0.01 multiplied by the malpractice GPCI of 0.822 is 0.008220. The sum of 0.622220 is multiplied by the Division conversion factor of \$56.20 for a total of \$34.97. The total MAR for 1 unit is \$34.97.

5. The recommended reimbursement is calculated as follows:

Date of Service	Procedure Code	Requested Amount	MAR	Insurance Paid	Recommended
2/3/2015	97110-GP-59	\$214.08	\$124.14	\$130.29	\$0.00
2/3/2015	97140-GP	\$67.50	\$34.97	\$36.47	\$0.00
2/13/2015	97110-GP-59	\$214.08	\$124.14	\$51.72	\$72.42
2/13/2015	97140-GP	\$67.50	\$34.97	\$0.00	\$34.97
2/25/2015	97140-GP	\$67.50	\$0.00	\$0.00	\$0.00
Total					\$107.39

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$107.39.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$107.39 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	January 29, 2016 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.